04449

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 335

1. PLACE OF DEATH:

County: Wicomico

City or town: Sharptown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 4 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Sharptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: no

(If rural, give LOCATION)

2.(a) If veteran, name war: Don't know

3.(a) FULL NAME Ray Bagwell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	C a	Don't know

6.(b) Name of husband or wife: no

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): about 1912

8. AGE:

Years	Months	Days	If less than one day
about 35			..... hrs. ..... min.

9. Birthplace: Northampton County Virginia

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER

12. Name: Laurance Bagwell

13. Birthplace: Northampton County Va.

MOTHER

14. Maiden name: Mary Bailey

15. Birthplace: Northampton County Va.

16. Informant: Mrs Laurance Bagwell

Address: Cheriton Virginia

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 12, 1947 (month) (day) (year)

Cemetery or crematory: Public

Location: Salisbury Md

18. Funeral director: James D. Stewart

Address: Salisbury Md

19. May 11 1947 (Date rec'd by registrar) Nellie F. Mason Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1947 at about 3-9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Burns of entire Body	sudden death
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 5/10/47

Where did injury occur? Sharptown Wicomico Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: home burned up with pt. asleep inbed Injured at work? No

23. SIGNATURE: Jas Rademaker MD Deputy Md & Coroner

M. D. or other

Address: Salisbury Md Date signed 5/10/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Trader

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04450

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH Wicomico

County ..... Eden

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: R.D. #1

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Eden (If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #1 (If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Cora Belle Banker

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: Isaac Henry Banker

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 7 - 1866

8. AGE: Years: 81 Months: 1 Days: 11 If less than one day: ..... hrs. ..... min.

9. Birthplace: near Fruitland Md (Town, county, and state)

10. Usual occupation: at Home

11. Industry or business .....

FATHER — 12. Name: John Pusey

FATHER — 13. Birthplace: R.D. Fruitland Md.

MOTHER — 14. Maiden name: Emma Pusey

MOTHER — 15. Birthplace: R.D. Fruitland Md.

16. Informant: Mr. Earl D. Banker

Address: R.D. #1. Eden Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20-47 (month) (day) (year)

Cemetery or crematory: Fruitland Cem.

Location: Fruitland Md

18. Funeral director: Holloway & Walter R. Holloway

Address: Salisbury Md.

19. 6-20-47 (Date rec'd by Registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18th 1947 at 5 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16, 1947 to May 18, 1947 and that I last saw her alive on May 17, 1947

Immediate cause of death	DURATION
Cerebro vascular Accident	2-days
Due to Hypertensive Cardio-vascular disease	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Manner of Injury ..... Injured at work?

23. SIGNATURE Charles W. Trader, M.D. M. D. or other

Address Salisbury Md Date signed 5-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr Rademaker

04451

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 9 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County or Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Bowers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1947

8. AGE: Years | Months | Days | If less than one day 9 hrs. min.

9. Birthplace Salisbury Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Bradle John
13. Birthplace North Carolina

MOTHER 14. Maiden name Bowers, Anita Mallya
15. Birthplace Berlin, Md.

16. Informant
Address

17. Cremation
(Burial, cremation, or removal. Which?) Date thereof 5/27/47
(Month) (day) (year)
Cemetery or crematory Peninsula Funeral Home
Location Salisbury Md.

18. Funeral director C. L. [illegible]
Address Salisbury, Md.

19. 5/27/1947 Earl L. Johnson Local Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1947, at 2:22 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 1947, to May 25 1947
and that I last saw h[illegible] alive on May 24 1947

Immediate cause of death	DURATION
Premature	5 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. A. Rademaker M.D.
M. D. or other
Address Salisbury Md. Date signed 5/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. Mayer.

04452

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Delaware County Sussex
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Brewington, Nannie Lester

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Boy	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 12, 1947

8. AGE: Years | Months | Days | If less than one day: 3 hrs. ..... min.

9. Birthplace Salisbury, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Reginald Brewington
13. Birthplace Laurel Delaware

MOTHER
14. Maiden name Miriam Johnson
15. Birthplace Philadelphia, Penn.

16. Informant
Address

17. Cremation (Burial, cremation, or removal. Which?) ✓ Date thereof May 12, 1947 (month) (day) (year)
Cemetery or crematory Peninsula General Hospital
Location Salisbury Maryland

18. Funeral director
Address

19. 6/13/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, at 10:30 A.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from 5/12/47 19.., to 5/12/47 19..; and that I last saw h.. alive on ..... 19.....

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles M. Mayer M. D. or ~~other~~
Address Laurel Del Date signed 5/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04453

Reg. Diat. No. 933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since March 10, 1945

Hospital, institution, or street address where death occurred: E. S. Tb. Sana., Salisbury, Md.

How long in hospital or institution? Since March 10, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn Infants give residence of mother)

State: Maryland County: Dorchester

City or town: Vienna (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Brinsfield, Julian B.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mary Catherine Brinsfield 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 21, 1878

8. AGE: Years	Months	Days	If less than one day
68	4	19	hrs. min.

8. Birthplace: Dorchester County, Md. (Town, county, and State)

10. Usual occupation: Salesman

11. Industry or business:

FATHER 12. Name: Dennard Brinsfield

13. Birthplace: Maryland

MOTHER 14. Maiden name: Virginia Thompson

15. Birthplace: Maryland

16. Informant: self

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-12-1947 (month) (day) (year)

Cemetery or crematory: Brookview

Location: Brookview Md

18. Funeral director: Graves Bros

Address: Sharptown Md

19. 5/11/47 (Date rec'd by registrar) M. Harris Ed. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 19 47 at 4:20 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on ..... 19.....

Immediate cause of death	DURATION
Far Advanced	
Pulmonary Tuberculosis	3 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lee L Lawry M.D. M. D. or other

Address: Salisbury, Maryland Date signed: 5/10/47

Dr. Chas. Fischer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164e

CERTIFICATE OF DEATH CB

04454

Reg. Dist. No. 393

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 days

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Delaware Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Culver, Polly

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	white	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ...... years

7. Birth date of deceased (mo., day, yr.): aug 31 - 1877

8. AGE: Years	Months	Days	If less than one day
69	—		...... hrs. ...... min.

9. Birthplace: Delmar Del
(Town, county, and state)

10. Usual occupation: Seamstress

11. Industry or business: —

FATHER

12. Name: Hardy Culver

13. Birthplace: Delmar Del

MOTHER

14. Maiden name: Amy Lynch

15. Birthplace: Delmar Del

16. Informant: S. M. Culver

Address: Delmar Del

17. ~~Burial~~ Date thereof: 6-2-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or ~~crematory~~: Smith Mills

Location: Delmar Del

18. Funeral director: W. S. Harvel Co.

Address: Delmar, Del.

19. 6/2 (Date rec'd by registrar) 19.. H. T. Hallett, Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31, 1947, at 3:05 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiners Certificate 19.. to 19.., and that I last saw h.. alive on ...... 19..

	DURATION
Immediate cause of death: Fracture of both legs	30 days
Due to: Fall from attic	
Due to: Suicide Attempt	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...... Date of op. ......

Autopsy results ......

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 5/1/47

Where did injury occur? Delmar (City or town) (County) Del (State)

Injured at home, farm, industry, public place (where?): At Home

Means of injury: Jumped from window Injured at work? no

23. SIGNATURE: Chas. G. Fischer, Deputy Medical Examiner M. D. or other

Address: Salisbury Md Date signed: 5/31/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

M I T

04455

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

Reg. Dist. No. 3-33

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address (where death occurred?) 101 Camden St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 101 Camden St (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Octavia Frances Dixon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife W m H. Dixon
6.(c) If alive, give age Dead years
7. Birth date of deceased (mo., day, yr.) Oct. 21 1872

8. AGE: Years 74 Months 6 Days 22 If less than one day ....hrs. ....min.

9. Birthplace R D Salisbury Md (Town, county, and state)
10. Usual occupation Home Work & Home
11. Industry or business
FATHER 12. Name Isaac W. Sherman
13. Birthplace Sussex Co. Del
MOTHER 14. Maiden name Martha E. Pilchyan
15. Birthplace R.D. Salisbury Md.
16. Informant Mr. Wm Dixon
Address 101 Camden St. Salisbury Md.
17. Burial (Burial, cremation, or removal? Which?) Date thereof May 16 47 (month) (day) (year)
Cemetery or crematory Parsons Mem.
Location Salisbury Md
18. Funeral director Hollowell & Co. Walter R. Hollowell
Address Salisbury Md
19. 5/16 1947 Harriet E. Johnson Registrar (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947 at 9:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 to May 13 1947 and that I last saw her alive on May 11 1947

	DURATION
Immediate cause of death (A) Coronary Thrombosis	2 hrs
Due to (B) Valvular Heart Disease	22 yrs
Due to	
Other conditions Hypertension (explain)	22 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo. R. Mann M. D. or other
Address Salisbury Md Date signed 6/14/47


RECEIVED
MAY 22 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

04456

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Prince
City or town: Pittsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred: R.D. #2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For nonresidents give residence of mother)
State: Md County: Worcester
City or town: Pittsville (If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Gertrude Donoway

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Albert Donoway
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): July 30 - 1882
8. AGE: Years 64 Months 9 Days 15 If less than one day: hrs. min.
9. Birthplace: Worcester Co. Md (Town, county, and state)
10. Usual occupation: Home work
11. Industry or business: at Home
FATHER 12. Name: Isaac Peter Powell
FATHER 13. Birthplace: Worcester Co. Md
MOTHER 14. Maiden name: Sarah Timmons
MOTHER 15. Birthplace: Worcester Co. Md
16. Informant: Mrs. Bessie Huffman
Address: R.D. #2 Pittsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18 1947 (month) (day) (year)
Cemetery or crematory: Pinnacle Cem.
Location: Worcester Co. Md
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.
19. 5/18/1947 (Date rec'd by registrar) Rebecca E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1947 at 5:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1947 to May 15 1947
and that I last saw h-- alive on May 14 1947
Immediate cause of death: Hypertension — Acc. + Obdisease — DURATION 2 yrs.
Due to: Essential hypertension — 4 yrs.
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. V. Fooks M. D. or other
Address: Delmar Del Date signed: 5-17-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

04457

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Parsons Burg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Parsonsburg Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Worden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colg	married

6.(b) Name of husband or wife: Lewis Worden
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Apr. 6. 1887

8. AGE: Years 66 | Months 6 | Days — | If less than one day: ____ hrs. ____ min.

9. Birthplace: miss. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Adams Mason
13. Birthplace: Richmond, va

MOTHER
14. Maiden name: Mary J. Mason
15. Birthplace: unknown

16. Informant: Edwin Smith
Address: Parsonsburg, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 3, 1947 (month) (day) (year)
Cemetery or crematory: Mason Cem
Location: Magnolia Miss.

18. Funeral director: J. Booker M West.
Address: Salisbury Md.

19. 6/31/47 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1947, at undetermined M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__ and that I last saw him alive on ____ 19__

Immediate cause of death	DURATION
Coronary Occlusion	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: none Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: LaRademaker MD Deputy med Examr M. D. or other

Address: Salisbury, Md Date signed: 5/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age. Item 1 is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04458

CERTIFICATE OF DEATH

Reg. Dist. No. 3329

1. PLACE OF DEATH:

County: Wicomico

City or town: Parsonsburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Parsonsburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Jennatty Ellen Downs

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph M. Downs

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 15th 1864

8. AGE: Years	Months	Days	If less than one day
82	7	7	..... hrs. ..... min.

9. Birthplace: Worlons Branch Del (Town, county, and state)

10. Usual occupation: Midwife

11. Industry or business

FATHER — 12. Name: Painter Dukes

13. Birthplace: Sussex Del

MOTHER — 14. Maiden name: Rachel Watson

15. Birthplace: Sussex Co Del

16. Informant: Mrs Pearl Windsor

Address: Parsonsburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 25-1947 (month) (day) (year)

Cemetery or crematory: Pine Hill E. Cemetary

Location: Near Whitesville Del

16. Funeral director: Wm Howard Wells

Address: Pittsville Md

19. 5-26-47 (Date rec'd by registrar) 19 H. L. Parker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 19 47 at 4-25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 19 45, to May 22, 19 47 and that I last saw h... alive on May 22, 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to	
Due to	
Other conditions Hypertension Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of ...

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank K Lewis M.D.

M. D. or other

Address: Willards Md Date signed: 5-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Kitts

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1190

04459

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. RD #3 (Zion Road) (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME (Downs)
Raymond Franklin Downs

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) March 10 1947

8. AGE: Years | Months: 2 | Days: 7 | If less than one day: ... hrs. ... min.

9. Birthplace: RD #3 Salisbury Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name: FATHER: Raymond Thomas Downs
Birthplace: Salisbury Maryland

13. Name: MOTHER: Katherine Virginia Fitzgerald
14. Birthplace: Elkton Md.

15. Informant: Mrs. Raymond T. Downs
Address: RD #3 Salisbury Md.

16. Burial (Burial, cremation, or removal. Which?) Date thereof: May 19-47 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Mem. Park
Location: Salisbury Md.

17. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland

18. (Date rec'd by registrar) 5/19/47 Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17th 1947, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 March 1947, to 17 May 1947
and that I last saw h.. alive on 14 May 1947

	DURATION
Immediate cause of death: Infectious diarrhea of the newborn	2 weeks
Due to: Cause unknown	
Due to: Petichial Hemorrhages	not determined.
Other conditions: Duodenal intestinal Infections diarrhea	
Bronchopneumonia (Include pregnancy within 3 months of death)	12 hours

Major findings of operations: ... Date of op. ...
Autopsy results: as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Nature of injury ... Injured at work?

23. SIGNATURE: ... M. D. or other
Address: Salisbury, Md. Date signed 5/19/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore • 83a

CERTIFICATE OF DEATH

04460 330

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Near Mardela
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wic
City or town: Mardela R.D. Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME J. Hamilton Evans

3. (b) Social Security Number

4. Sex: M
5. Color or race: White
6.(a) Single, married, widowed, or divorced
6.(b) Name of husband or wife: Elsie P. Evans
6.(c) If alive, give age: 79 years
7. Birth date of deceased (mo., day, yr.): June 15 1868

8. AGE: Years: 78 Months: 11 Days: 5 If less than one day: hrs. min.

9. Birthplace: Mardela R.D. Wic Md. (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:

FATHER
12. Name: Ichabod D. Evans
13. Birthplace: Md

MOTHER
14. Maiden name: Eliza A. Russell
15. Birthplace: Md

16. Informant: Mrs Minnie Laybrill
Address: Mardela R.D. Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof 5 22 1947 (month) (day) (year)
Cemetery or crematory: Family Cemetery
Location: Near Maddela Md
18. Funeral director: Graveyard Bros
Address: Shaptown

19. 5/22/47 (Date rec'd by registrar) W H Robertson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1947, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 27 1946, to May 20 1947
and that I last saw h. alive on May 19 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	11
Due to:	
Due to:	
Other conditions: Hy postatic Pneumonia	2 day

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. S. Kuhlman M. D. or other
Address: Shaptown Md Date signed 5/22/47

Gilmore

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

04461

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yr. 8 Mo. 2 mo.
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Lakeland
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Feeney Mr. James A.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Feeney Mrs. Theresa
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): May 18 - 1894

8. AGE: Years: 52 Months: [redacted] Days: 24 If less than one day: hrs. min.

9. Birthplace: Brooklyn N.Y. (Town, county, and state)
10. Usual occupation: Owner of
11. Industry or business: Glass Company

FATHER
12. Name: John Feeney
13. Birthplace: Long Island N.Y.

MOTHER
14. Maiden name: Mary E. McDonnell
15. Birthplace: Long Island N.Y.

16. Informant: Mrs. Theresa A. Feeney
Address: Lakeland, Salisbury Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16-47 (month) (day) (year)
Cemetery or crematory: Wic. Mem. Park
Location: Salisbury Maryland
18. Funeral director: Hollmans Walter R. Hollman
Address: Salisbury Maryland.

19. 5/16/47 (Date rec'd by registrar) Harriet A. Dennis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1947, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1947 to May 12 1947
and that I last saw him alive on May 12 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 hours
Due to: Hypertension, essential	Symptoms 6 yrs.
Due to:	Symptoms 24 hours
Other conditions: Hypertensive Encephalopathy	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: — Injured at work?

23. SIGNATURE: David J. Gilmore M.D.
Address: 130 N. Division St. Salisbury, Md. M. D. or other
Date signed: May 12 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

04462

Reg. Diat. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mo. at this addr
Hospital, institution, or street address where death occurred 185. Cherry St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 706 Brown St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Thomas Ford

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Addie E. Ford
6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) July 2nd 1870

8. AGE: Years 76 | Months 10 | Days 3 | If less than one day ... hrs. ... min.

9. Birthplace Ouiola Maryland
(Town, county, and state)

10. Usual occupation retired
11. Industry or business Carpenter

FATHER
12. Name Silas Ford
13. Birthplace Somerset Co. Md.

MOTHER
14. Maiden name Sallie Shockley
15. Birthplace Somerset Co. Md.

16. Informant Mr. Harry S. Ford
Address 303 Roslyn Ave. Baltimore 12. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8-1947 (month) (day) (year)
Cemetery or crematory Parkwood Cemetery
Location Baltimore Maryland.

18. Funeral director Hillman & C. Walter R. Hillman
Address Salisbury Maryland

19. 5-6 (Date rec'd by registrar) 1947 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5th 1947 at 4. P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 30 1945 to May 5 1947 and that I last saw him alive on May 3 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Arteriosclerotic C-V Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William D. Gray M.D. M. D. or other
Address Salisbury Md. Date signed 5/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04463

Reg. Dist. No. 533

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Jan. 23, 1947

Hospital, Institution, or street address where death occurred:
E. S. Tb. Sanatorium, Salisbury, Md.

How long in hospital or institution? Since 1/23/47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 204 Race St.,
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Furniss, Paul

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Bertie Olson Furniss

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1890

8. AGE:

Years	Months	Days	If less than one day
56	7	19	...hrs. ...min.

9. Birthplace: Somerset County, Maryland
(Town, county, and state)

10. Usual occupation: Bricklayer

11. Industry or business:

FATHER
12. Name: William Furniss
13. Birthplace: Maryland

MOTHER
14. Maiden name: Addie Austin
15. Birthplace: Maryland

16. Informant: self
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27, 1947 (month) (day) (year)

Cemetery or crematory: John Westley

Location: Mt. Vernon, Md.

18. Funeral director: Dale D. Schiell

Address: Princess Anne Md.

19. 5/30/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 19 47 at 7:40a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 23 19 47 to May 25 19 47 and that I last saw him alive on May 25, 1947 19...

Immediate cause of death	DURATION
Pulmonary Tuberculosis	15 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ...Injured at work?

23. SIGNATURE: Paul Chew M.D.
M. D. or other

Address: Salisbury Md. Date signed: 5/30/47

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164c

04464

CERTIFICATE OF DEATH

Reg. Diat. No. 393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one day

Hospital, institution, or street address where death occurred: Peninsula General Hospital, Salisbury

How long in hospital or institution? Seven hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Brooklyn Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Mrs. Dally Delonnie Green

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband ~~or wife~~: Gilbert Green

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 10th 1912

8. AGE: Years	Months	Days	If less than one day
34	6	19	..... hrs. ..... min.

9. Birthplace: Salisbury Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: E. Henry West

13. Birthplace: Pocomoke Maryland

MOTHER 14. Maiden name: Jennie E. Avery

15. Birthplace: Pocomoke Maryland

16. Informant: Mrs Elsie Sapienza 107 Brooklyn Ave Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 2-47 (month) (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury Maryland

18. Funeral director: Wellons & Son Walter R. Wellons

Address: Salis'y Md

19. 6-31 1947 Registered Delivered (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29th 1947, at 7:57 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19..... and that I last saw h... alive on ..... 19..... Medical Examiners Certificate

Immediate cause of death	DURATION
Gunshot wound of Head	sudden
Due to: Self-inflicted	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: May 29th 1947

Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Gunshot wound Injured at work? No

23. SIGNATURE: Clem E. Fischer M.D. M. D. or other

Address: Salisbury Md Date signed: 5/30/47

Dr. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

04466

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 years

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 6 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 434 Newton

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Hitch Mrs. Esther Darby

3. (b) Social Security Number ✓

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife George R. Hitch, Sr.

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) May 19, 1874

8. AGE: Years 72 Months 11 Days 23 If less than one day ... hrs. ... min.

9. Birthplace Green Hill, Wicomico, Md.

(Town, county, and state)

10. Usual occupation At Home

11. Industry or business ✓

FATHER

12. Name Richard James Darby

13. Birthplace Wicomico Co. Md.

MOTHER

14. Maiden name Laura Gertrude Ennis

15. Birthplace Wicomico Co., Md.

16. Informant Mrs Charles T. Hewitt

Address 3342 N. 13th St., Phila. Pa.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 5/14/47 (month) (day) (year)

Cemetery or crematory Parsons

Location Salisbury, Md.

18. Funeral director The Hill & Johnson Co.

Address Salisbury, Md.

19. 5/14, 1947 Harriet A. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947 at 12 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1947, to May 12 1947

and that I last saw her alive on May 12 1947

	DURATION
Immediate cause of death Cardio-nephritis	3 yrs
Due to	
Due to	
Other conditions 2 fracture	7 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hance R Mann M. D. or other

Address Salisbury Md. Date signed 5/12/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

04467

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: R.D. #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For nonborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John William Hitch

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Susie A. Hitch
6.(c) If alive, give age: 69 years
7. Birth date of deceased (mo., day, yr.): July 29-1870
8. AGE: Years: 76 Months: 10 Days: 5 If less than one day: hrs. min.
9. Birthplace: Wicomico Co. Md. (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:

FATHER
12. Name: Samuel H. Hitch
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Hettie A. Disharoon
15. Birthplace: Wicomico Co. Md.

16. Informant: Mr. Raymond A. Hitch
Address: R.D. #1. Salisbury Md.

17. Burial, cremation, or removal, Which?: Burial Date thereof: June 1-47 (month) (day) (year)
Cemetery or crematory: Fruitland Cem.
Location: Fruitland Maryland

18. Funeral director: Wilson & Walter R. Wilson
Address: Salisbury Md.

19. (Date rec'd by registrar) 6/31/47 H. Eugene Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 19 47 at 10 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-1-47 19 to 5-29-47 19 and that I last saw him alive on 5-29-47 19

Immediate cause of death	DURATION
Cardiac Decompensation	1 wk
Due to	
Due to	
Other conditions: Diabetes - Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lee L Lauer M.D. M. D. or other
Address: Fruitland, Md. Date signed: 5-31-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Kramer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04468

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico

County

City or town Parsonsburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: R.D.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For non-residents give residence of mother)

State Md. County Wicomico

City or town Parsonsburg (If outside city or town limits, write RURAL and give nearest town)

Street No. R.D.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Samuel Theodore Hobbs

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Millie J. Hobbs

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) July 10-1875

8. AGE: Years 71 | Months 10 | Days 14 | If less than one day hrs. min.

9. Birthplace R.D. Parsonsburg Md. (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Rider Hobbs

13. Birthplace R.D. Parsonsburg Md.

MOTHER 14. Maiden name White

15. Birthplace unknown

16. Informant Mrs. Millie J. Hobbs

Address R.D. Parsonsburg Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 26 1947 (month) (day) (year)

Cemetery or crematory Bethel Cem.

Location Pocomoke Md.

18. Funeral director Holloway & Walter R. Holloway

Address Salisbury Maryland

19. 6/26/47 (Date rec'd by registrar) Harriet L. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947 at 2.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1947 to May 24 1947 and that I last saw him alive on 5/24/47 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Arterio sclerosis.	
Due to	
Other conditions Terminal bronchopneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. L. Kramer M.D. M. D. or other

Address Salisbury Md. Date signed 6/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

04469

Reg. Dist. No. 383

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 1/2 days.

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 38 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Worcester

City or town: Snow Hill.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: John Johnson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Unknown

6.(b) Name of husband or wife:

6.(c) If alive, give age: ....years

7. Birth date of deceased (mo., day, yr.): Unknown 1887

8. AGE: Years	Months	Days	If less than one day
about 60			....hrs. ....min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace "

MOTHER 14. Maiden name: Unknown

15. Birthplace "

16. Informant: Peninsula General Hospital

Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 17/47 (month) (day) (year)

Cemetery or crematory: Coulbourne's

Location: Fruitland, Md

18. Funeral director: Allan E. Timmons

Address: Snow Hill Md

19. 5-16, 1947 (Date rec'd by registrar) Harold E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1947, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4-6 1947, to 5-13 1947

aed that I last saw h... alive on 5-13 1947

Immediate cause of death	DURATION
Generalized arteriosclerosis	
Myocardial Fatis	
Due to	
Due to	
Other conditions: infected ulcers both legs.	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William A. Tilghman Jr. M. D. or other

Address: Salisbury Md Date signed: 5-14-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

D(CW) 04470

Reg. Dist. No. 4-1336

1. PLACE OF DEATH:

County: Wicomico

City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day.

Hospital, Institution, or street address where death occurred:
R F D # 3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R F D # 3
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Benjamin E. Kimmey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma Kimmey

6.(c) If alive, give age: 88 years

7. Birth date of deceased (mo., day, yr.): Dec. 20 1871

8. AGE:

Years	Months	Days	If less than one day
75			...hrs. ...min.

9. Birthplace: Secretary Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER
12. Name: Wm. Kimmey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sandy Shorter
15. Birthplace: Maryland

16. Informant: Emma Kimmey
Address: Delmar Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-7-47 (month) (day) (year)
Cemetery or crematory: East Market
Location: East New Market, Md.

18. Funeral director: H. S. Hyland Co
Address: Delmar, Del

19. May 6, 1947 (Date rec'd by registrar) Harry E. Hudson, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1947 at 2 00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1947 to May 5 1947
and that I last saw h alive on May 2 1947

Immediate cause of death	DURATION
Uremia	
Due to: Arteriosclerotic C-V-R	
Due to: Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William D Gray M.D.
M. D. or other

Address: Salisbury Md. Date signed: 5/7/47

VS AID 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

04471

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH (149-6)

Reg. Dist. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 1 hr. 25 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lankford Mrs. Lynn

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Lankford Mr. Lynn
6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): May 17 1919

8. AGE:

Years	Months	Days	If less than one day
27	11	26	hrs. min.

9. Birthplace: Galestown Dorchester Md
(Town, county, and state)
10. Usual occupation: House work
11. Industry or business
FATHER 12. Name: Herman C. Henry
13. Birthplace: Md
MOTHER 14. Maiden name: Maggie E. Dunn
15. Birthplace: Md
16. Informant: Albert Henry
Address: Sharptown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-16-47 (month) (day) (year)
Cemetery or crematory: Firemans
Location: Sharptown
1B. Funeral director: Grantmyer Bros
Address: Sharptown
19. (Date received by registrar) 6/13, 1947 Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1947, at 4 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1947, to May 12 1947
and that I last saw h[illegible] alive on May 12 1947

Immediate cause of death	DURATION
(a) Strangulated Ileus	
Secondary to Ca Cecum	
Due to (b) Child birth - June	
Anesthesia	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: T. S. Kuhlman M. D. or other
Address: Sharptown Md Date signed: 6/12/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04472

46e

CERTIFICATE OF DEATH

Reg. Diat. No. 353

1. PLACE OF DEATH:

County: Wicomico

City or town: Parsonsburg R.7.D.#1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Parsonsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.7.D. #1

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: James Handy Laws

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Leah Catherine Laws

6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): Oct. 14, 1856

8. AGE:

Years	Months	Days	If less than one day
90	7	12	...hrs. ...min.

9. Birthplace: Wango, Wicomico Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Farmer

FATHER — 12. Name: William Levin Laws

FATHER — 13. Birthplace: Wango, Md.

MOTHER — 14. Maiden name: Margaret Fooks

MOTHER — 15. Birthplace: Pittsville, Maryland

16. Informant: Mrs. Leah C. Laws

Address: Parsonsburg R.7.D.#1

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 29-1947 (month) (day) (year)

Cemetery or crematory: Laws Family Cemetery

Location: Near Wango, Maryland

18. Funeral director: Holloway & Co. - Walter R. Holloway

Address: Salisbury, Maryland

19. 5/29 1947 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26th 1947, at 7.20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. '46 19.. to May 26 19 47

and that I last saw h. alive on 5-25-47 19..

Immediate cause of death	DURATION
Coronary Thrombosis	2 hours
Due to	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Lee L. Laws, M.D.

M. D. or other

Address: Fruitland, Md. Date signed: 5-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

(Ms. Goe)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

04473

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury Md. 415 Davis st.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Weeks
Hospital, institution, or street address where death occurred:
Wrights Nursing Home
How long in hospital or institution? 6 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Wicomico
City or town Eden Md R.F.D # 2
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route # 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Eleanor Malone

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Charlie H. Malone
6.(c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) aug. 2nd. 1881

8. AGE: Years	Months	Days	If less than one day
65	9	2	....hrs. ....min.

9. Birthplace Pilsoro md (Town, county, and state)
10. Usual occupation Home Wife
11. Industry or business at home

FATHER
12. Name John Fields
13. Birthplace Old Shad Point Md.

MOTHER
14. Maiden name Emma Brumbley
15. Birthplace Near Trultland's md.

16. Informant Charlie H. Malone
Address Eden Md R.F.D. # 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17 1947 (month) (day) (year)
Cemetery or crematory Pilsoro Church Cemetery
Location Pilsoro Md.
18. Funeral director Holloway & Co. Inc. Director
Address 520 E. Church St. Salisbury Md

19. 5-17-47 (Date rec'd by registrar) Margaret E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14th 1947 at 1.05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1947 to May 14 1947 and that I last saw h.r alive on May 14 1947

Immediate cause of death	DURATION
Renal Failure	1 day
Due to Cerebral Hemorrhage	5 days
Due to Arteriosclerosis & Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert Gore M. D. or other
Address Salisbury, Md. Date signed 5-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

04474

CERTIFICATE OF DEATH

Reg. Dist. No. 393

1. PLACE OF DEATH:
County: Wicomico Co
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58 yrs
Hospital, institution, or street address where death occurred: RD #2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico Co
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. # 2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Irene Etta Marshall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Samuel B. Marshall
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Feb. 9-1873

8. AGE:

Years	Months	Days	If less than one day
74	3	9	..... hrs. ..... min.

9. Birthplace: RD #2 Salisbury Md
(Town, county, and state)
at Home

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Reuben Washburn
13. Birthplace: Lebanon Md.

MOTHER
14. Maiden name: Elizabeth Taylor
15. Birthplace: Salisbury Md

16. Informant: Mrs. Annie L. Marshall
Address: RD #2 Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 22-47 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md

18. Funeral director: Hollaway & Walter R. Holloway
Address: Salisbury Md

19. 6-2/22, 1947 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1947 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 to May 18- 1947 and that I last saw him alive on May 18 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 days
Due to: Hypertension -	10 yrs
Due to:	
Other conditions: Cardio-Nephritis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Nature of injury: ..... Injured at work?

23. SIGNATURE: Irene R Mann M. D. or other
Address: Salisbury Md Date signed 3/9/47

M

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04475

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 Chestnut St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elephant Mrs. Effie

3.(b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Elephant Mr. James S.

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): May 21 1884

8. AGE: Years: 62 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Wicomico County, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: Jacob Wm. Nichols

13. Birthplace: Wicomico County, Md.

MOTHER
14. Maiden name: Henrietta Nichols

15. Birthplace: Wicomico County, Md.

16. Informant: J. Stewart Elliott

Address: Delmar, Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-6-47 (month) (day) (year)

Cemetery or crematory: St. Olive Methodist

Location: Delmar, Del.

18. Funeral director: W. E. Mandl & Co

Address: Delmar, Del.

19. 5/7 1947 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1947 at 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to May 4 1947

and that I last saw h.r alive on May 4 1947

	DURATION
Immediate cause of death: Hemoptisis	
Due to: Pulmonary Tuberculosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. V. Fahey M.D.
M. D. or other

Address: Delmar, Del. Date signed: May 6 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

04476

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico Co

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Most years

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico Co

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 405 S Gordon St

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME Lillie B Parker

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Married

6.(b) Name of husband or wife: Jessie Parker

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1897

8. AGE:

Years	Months	Days	If less than one day
50			..... hrs. ..... min.

9. Birthplace: Seaford Del

(Town, county, and state)

10. Usual occupation: Housekeeping

11. Industry or business: Same As Above

FATHER

12. Name: E L Chapple

13. Birthplace: Seaford Del

MOTHER

14. Maiden name: Ann Brown

15. Birthplace: Arkansas

16. Informant: Cathrin Briggs

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 24 1947 (month) (day) (year)

Cemetery or crematory: Mount Zion

Location: Zion Church Md

18. Funeral director: James H Bloyd

Address: Salisbury Md

19. 5-23-47 (Date rec'd by registrar) Harriet E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 1947, at about 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...

and that I last saw him alive on May 21 1947

Immediate cause of death	DURATION
Coronary occlusion	4 yrs before death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide ..... Date of .....

Where did Injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE: for Rademacher MD Deputy Med Examiner

M. D. or other

Address: Salisbury Md Date signed: 5/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

127a

04477

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No. 209 East Street.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Washington Ruben Parsons

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: May Parsons

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): May 20 ± 1887

8. AGE:

Years	Months	Days	If less than one day
59	11	11	...hrs. ...min.

9. Birthplace: Delmar Maryland
(Town, county, and state)

10. Usual occupation: retired

11. Industry or business: Railroad worker

FATHER
12. Name: Irving Parsons
13. Birthplace: Worcester Co. Md.

MOTHER
14. Maiden name: Ella Carey
15. Birthplace: Worcester Co. Maryland

16. Informant: Mrs. May Parsons

Address: 209 East st. Delmar Md

17. Burial (Burial, cremation, removal. Which?) Date thereof: May 4-1947 (month) (day) (year)

Cemetery or crematory: M.P. Cem.

Location: Delmar Delaware

18. Funeral director: Holloway & Walter R. Holloway

Address: Salisbury Maryland

19. 5/2/ 19... Harriet E. Johnson Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1947, at 8 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-29 1947, to 5-1 1947

and that I last saw h... alive on 4-30 1947

Immediate cause of death	DURATION
Bronchopneumonia	
Due to: acute leukocytosis & generalized peritonitis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Linda A. Insley M. D. or other

Address: Salisbury Md Date signed: 5-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

04478

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico co
City or town: Salisbury Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury Md. (If outside city or town limits, write RURAL and give nearest town)
Street No.: Lake St. Ex. Route #2 (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Eugene T. Partlowe

3.(b) Social Security Number

4. Sex: male
5. Color or race: col
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife: —
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): May 14, 1947
8. AGE: Years — Months — Days 3 If less than one day — hrs. ... min.
9. Birthplace: Salisbury Md (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: Luther Partlowe
13. Birthplace: Flint Mich

MOTHER
14. Maiden name: Thelma Walker
15. Birthplace: Salisbury Md.

16. Informant: Lillian Walker
Address: Lake St. Ex. Route 2.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 17, 1947 (month) (day) (year)
Cemetery or crematory: Public
Location: Salisbury Md.
18. Funeral director: Booker M. West
Address: 404 Lake St.
19. 5/17, 1947 (Date rec'd by registrar) Carrie E. Johnson Registrar

8 mo
040
Lillian G. Elsie
Smullhome

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17, 1947, at ... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19... and that I last saw h... alive on ... 19...
medical examiner ex officio

Immediate cause of death: Prematurity (7 month) — DURATION: 3 days
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [illegible] Deputy Med. Exam. M. D. or other
Address: Salisbury Md. Date signed 5/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d CP

Reg. Dist. No. 04479 336

1. PLACE OF DEATH:

County: Sussex

City or town: Delmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos

Hospital, Institution, or street address where death occurred: State Street

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lucy L. Phillips

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Lewis Phillips

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May - 7 - 1868

8. AGE: Years	Months	Days	If less than one day
78	11	26	hrs. min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER 12. Name: Lewis L. Phillips

13. Birthplace: Delaware

MOTHER 14. Maiden name: Emaline Banks

15. Birthplace: Delaware

16. Informant: E. Lewis Phillips

Address: Laurel Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7-1947 (month) (day) (year)

Cemetery or crematory: Odd Fellows Cemetery

Location: Laurel Del

19. Funeral director: A. Harvey Williams

Address: Federalsburg Md.

19. May 6, 1947 (Date received by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 - 1947, at 6.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 1946, to May 3 1947

and that I last saw h... alive on May 3 1947

Immediate cause of death	DURATION
Cardiac failure	
Due to Arteriosclerotic	
myocardosis	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause te which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. V. Fooks M. D. or other

Address: East St. Delmar Del Date signed 5-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Diat. No. 04484

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo 7 days

Hospital, institution, or street address where death occurred: 105 Ekeny Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: NO V

3.(a) FULL NAME: Se-Linda D. Price

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Edward A. Price

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 25 - 1876

8. AGE:

Years	Months	Days	If less than one day
71	3	17	..... hrs. ..... min.

9. Birthplace: Philadelphia Pa.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: William H. Quach.

13. Birthplace: Pa.

MOTHER 14. Maiden name: Unknown

15. Birthplace: "

16. Informant: William N. Price

Address: Fleetwood Pa.

17. (Burial, cremation, or removal) Which? Burial Date thereof: May 15/47 (month) (day) (year)

Cemetery or crematory: Episcopal

Location: Snow Hill, Md

18. Funeral director: Elbert E. Timmons

Address: Snow Hill, Md

19. 5/16 1947 Harriet E. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1947, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1947, to May 13 1947

and that I last saw h[illegible] alive on April 29 1947

	DURATION
Immediate cause of death: Pneumonia	
Due to: Cardiovascular Renal Dis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William N. Grier M.D.

M. D. or other

Address: Salisbury Md Date signed: 5/13/47

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1622

Jan

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

04481

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 5 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.7 B #2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Richardson Baby Boy.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 7, 1947

8. AGE: Years | Months | Days: 1 | If less than one day: ..... hrs. ..... min.

9. Birthplace Salisbury, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Refused to give name.

13. Birthplace

MOTHER 14. Maiden name Estelle Richardson

15. Birthplace Warren, N. Carolina

16. Informant Estelle Richardson

Address Salisbury, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 8 1947 (month) (day) (year)

Cemetery or crematory Peninsula General Hospital

Location Salisbury, Md.

18. Funeral director Peninsula General Hospital

Address Salisbury Md.

19. 6-10-47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947 at 4:35 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 1947 to May 8 1947

and that I last saw h[illegible] alive on May 8 1947

Immediate cause of death	DURATION
Respiratory failure	
Due to Prematurity	
Due to (5½ mo. gestation)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

5-8-47 Date of op.

Autopsy results Prematurity

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert R. Starr M. D. or other

Address Salisbury Date signed 5-8-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Gore

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

162a

CERTIFICATE OF DEATH

Reg. Diat. No. [illegible]

1. PLACE OF DEATH: Wicomico

County: Salisbury

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 415. Dans street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother.)

State: Md. County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 415. Dans street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Mary E. Russell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Samuel J. Russell

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Feb. 14-1870

8. AGE: Years: 77 | Months: 3 | Days: 3 | If less than one day: ...hrs. ...min.

9. Birthplace: Berlin Maryland
(Town, county, and state)

10. Usual occupation: at Home

11. Industry or business

FATHER
12. Name: John Mumford
13. Birthplace: Berlin Md.

MOTHER
14. Maiden name: Nancy Massey
15. Birthplace: Berlin Md.

16. Informant: Mr George W. Russell
Address: Fruitland Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20-47 (month) (day) (year)
Cemetery or crematory: Fruitland Memorial
Location: Fruitland Md.

18. Funeral director: Wm. G. Walter & Wm. Walter
Address: Salisbury Md.

19. 5/20/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17th 1947 at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6th 1947 to May 17, 1947
and that I last saw h[illegible] alive on May 17 1947

Immediate cause of death: Heart Failure. — DURATION: 24 hrs

Due to: Senile Psychosis

Due to:

Other conditions: Senile Psychosis.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Nature of injury: Injured at work?

23. SIGNATURE: Robert Gore M.D.
M. D. or other
Address: 302 N. Division St. Salisbury, Md. Date signed: 5/19/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct page. MARGIN RESERVED FOR BINDING. (I) (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04483

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico Co.

City or town: Salisbury Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5th yrs.

Hospital, Institution, or street address where death occurred: —

How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 405 Happy Alley (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Hattie Schofield.

3.(b) Social Security Number: 218-20-6490

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Single.

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 8. 1418

8. AGE: Years: 29 | Months: 1 | Days: | If less than one day: hrs. min.

9. Birthplace: Snow Hill Md. (Town, county, and state)

10. Usual occupation: Domestic.

11. Industry or business: none

FATHER — 12. Name: Raymond Schofield.

FATHER — 13. Birthplace: Snow Hill Md

MOTHER — 14. Maiden name: Hattie Cottingham

MOTHER — 15. Birthplace: Snow Hill Md.

16. Informant: Joyce Bowling

Address: 405 Happy Alley

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 4-1947 (month) (day) (year)

Cemetery or crematory: Green Cross Mem Park

Location: Salisbury, Md.

18. Funeral director: Booker M. West

Address: 404 Lake St. Salisbury

19. 5/3 (Date rec'd by registrar) 19 47 Harriet L. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 19 47 at 4 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Pulmonary T.b.c	3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. A. Radcliffe Deputy Med Exam M. D. or other

Address: Salisbury Md Date signed: 5/6/47

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VS A45 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04484

CERTIFICATE OF DEATH

Reg. Dist. No. 33 3

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 207 Cross

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 207 Cross (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sarah Shores

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Geo Levin Shores

6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Aug 2nd, 1874

8. AGE:

Years	Months	Days	If less than one day
72	9	7	..... hrs. ..... min.

9. Birthplace Deal Island Md. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business at home

FATHER 12. Name Benjamin Green

FATHER 13. Birthplace Mt. Vernon Md.

MOTHER 14. Maiden name Anna Parkinson

MOTHER 15. Birthplace Somerset County Md.

16. Informant Mrs. Lester Gordy

Address 305 E. Vine St. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 11, 1947 (month) (day) (year)

Cemetery or crematory St. Johns Cemetery

Location Deal Island Md.

18. Funeral director Holloway & Gordy, Funeral Directors

Address 320 E. Church St. Salisbury Md.

19. 5/10 1947 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1947, at 7.55 P.M.

21. I CERTIFY That death occurred on the date above stated; that I attended deceased from April 26, 1947, to May 9, 1947 and that I last saw her alive on May 9, 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arteriosclerosis Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Injured at work?

Means of injury

23. SIGNATURE John H. Yearman M.D. M. D. or other

Address 238 Camden Ave. Salisbury Date signed May 9, 1947

04485

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 333

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 1 Yr. 15 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R 7 D #2 (Quantico Road)

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME William Stanbury Short ~~Wilbur Short~~

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Margaret B. Short

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): Aug. 13 - 1911

8. AGE: Years 35 | Months 9 | Days 15 | If less than one day: hrs. min.

9. Birthplace: Salisbury Maryland

(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business:

FATHER 12. Name: William J. Short

13. Birthplace: Salisbury Md.

MOTHER 14. Maiden name: Alice Nicholas

15. Birthplace: Salisbury Maryland

18. Informant: Mrs. Margaret B. Short

Address: R.D. #2, Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 30-47 (month) (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury Maryland

16. Funeral director: Holloway & Walter R. Holloway

Address: Salisbury Maryland.

19. 5/30/1947 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 1947 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 - 1947 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thurza A. Insley M.D. or other

Address: Salisbury Md. Date signed: 5-30-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

04486

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Mardela
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Baby Smith

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 30 1947

8. AGE: Years | Months | Days | If less than one day: 6 hrs. 45 min.

9. Birthplace: Salisbury, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: George William Smith

FATHER — 13. Birthplace: Siloam, Md.

MOTHER — 14. Maiden name: Etta Marie Munro

MOTHER — 15. Birthplace: Bivalve, Md.

16. Informant: Mrs. Etta Marie Smith

Address: Mardela, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 31, 1947 (month) (day) (year)

Cemetery or crematory: Peninsula General Hosp.

Location: Salisbury, Md.

18. Funeral director: Peninsula General Hospital

Address: Salisbury Md

19. 6/2/47 (Date rec'd by registrar) 1947 Maggie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30, 1947, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Premature	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. L. Grams M.D.
M. D. or other

Address: Salisbury, Md. Date signed 6/30/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

CERTIFICATE OF DEATH

04465

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Register Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Smith Mr. Marion Harlan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Anna Walston Smith
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct. 16-1913

8. AGE: Years	Months	Days	If less than one day
33	6	28	..... hrs. ..... min.

9. Birthplace: Salisbury Maryland
(Town, county, and state)
10. Usual occupation: Auto Mechanic
11. Industry or business

FATHER
12. Name: Harlan A. Smith
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Emma Maria Parsons
15. Birthplace: Pittsville Md.

16. Informant: Mrs. Emma M. Marsh
Address: Register St. Salisbury Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: May 16-47
(month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland

18. Funeral director: Hollins & Co. Walter R. Hollins
Address: Salisbury Md.

19. 5-16-1947 Harriet E. Johnson Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1947 at 6.45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.....
and that I last saw ... alive on ..... 19.....

Immediate cause of death	DURATION
acute hepatitis	48 hrs
following psoriasis	
Due to	
Due to	
Other conditions: Laceration of scalp	48 hrs
Bruises of body	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. .....
Autopsy results: Cerebral hemorrhage
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Not Coroner
Accident, suicide, or homicide: accident Date of 5/13/47
Where did injury occur? Salisbury (City or town) Wicomico (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Fell & hit head Injured at work? No

23. SIGNATURE: [illegible] M. D. or other
Address: Salisbury Md. Date signed: 5/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

04487

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death: 7 years

Hospital, institution, or street address where death occurred: Parcella Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Parcella Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Ethel May Truitt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Lee F. Truitt

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): July 26 - 1897

8. AGE: Years: 49 Months: 9 Days: 10 If less than one day: hrs. min.

9. Birthplace: Philadelphia Pa.

(Town, county, and state)

10. Usual occupation: Home Keeper

11. Industry or business: at Home

FATHER — 12. Name: Edward Coffin

FATHER — 13. Birthplace: Millsboro Delaware

MOTHER — 14. Maiden name: Lillie Wells

MOTHER — 15. Birthplace: Frankford Delaware

16. Informant: Mr. Lee F. Truitt

Address: Parcella St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 9-1947 (month) (day) (year)

Cemetery or crematory: Wi Co. Mem. Park

Location: Salisbury Maryland

18. Funeral director: Hellings & G. Walter R. Hellings

Address: Salisbury Maryland

19. (Date received by registrar) 5-9-1947 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6th 1947 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20 1947, to May 6, 1947

and that I last saw h[illegible] alive on May 6, 1947.

Immediate cause of death	DURATION
Congestive Heart Failure	6 mos.
Due to: Myocarditis.	
Due to:	
Other conditions: Pleurisy with effusion	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John H. Yeaman M.D. M. D. or other

Address: 138 Camden Ave. Salisbury Md. Date signed: May 6, 1947.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

04440

CERTIFICATE OF DEATH

Reg. Diat. No. 327

1. PLACE OF DEATH:

County Wicomico

City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Isaac C. Wallace

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Widower

6.(b) Name of husband or wife Mary L. Wallace

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1874

8. AGE: Years	Months	Days	If less than one day
73	1	28	hrs. min.

9. Birthplace Nanticoke, Wicomico, Md.
(Town, county, and state)

10. Usual occupation Oysterman

11. Industry or business

FATHER 12. Name William Wallace

13. Birthplace Nanticoke, Md.

MOTHER 14. Maiden name Don't Know

15. Birthplace Nanticoke, Md.

16. Informant Olin Wallace

Address Nanticoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/8/47 (month) (day) (year)

Cemetery or crematory Cemetery

Location Nanticoke, Md.

16. Funeral director C. G. Messick

Address Bivalve, Md.

June 7 1947 (Date rec'd by registrar) R. Woolford Dalton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to May 4 1947

and that I last saw him alive on 24 April 1947

Immediate cause of death	DURATION
Arteriosclerotic Cardio-vascular disease with	10 days.
Due to cerebral thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard H. Saunders M.D.
M. D. or other

Address Nanticoke Md. Date signed May 7 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

C. H. O.

COPY SENT TO ~~LOCAL REGISTRAR~~ No. ____ DATE 6-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P4488

131a

Reg. Dist. No. 333

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING

VS/A15 9-45 15M

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Five years

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 208 Caltrete

(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME Ellie A Waren

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a. a.	widow

6.(b) Name of husband or wife Dunkie Waren Dead 6.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) Aug 15 about 1873

8. AGE: Years	Months	Days	If less than one day
73	-	-	....hrs. ....min.

9. Birthplace Delane Florida (Town, county, and state)

10. Usual occupation no

11. Industry or business no

FATHER 12. Name unknown

FATHER 13. Birthplace unknown

MOTHER 14. Maiden name unknown

MOTHER 15. Birthplace unknown

16. Informant Isaac Beckett

Address Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15 47 (month) (day) (year)

Cemetery or crematory Green Acres Memorial Park

Location Salisbury Md

18. Funeral director James H Stewart

Address Salisbury Md

19. 6-16-47 (Date rec'd by registrar) Harriet L Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 15 1947 to 1947

and that I last saw h.. alive on May 12 1947

Immediate cause of death	OURATION
Apoplexy	1 Month
Due to Hypertension	
Renal	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. A. Purnell, M. D. M. D. or other

Address 800 W. Main Date signed 5-14-47

Dr. Gramm

04489

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days.

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 8 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Washburn, Mr. William Arthur.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Mrs. Edna E. Washburn.

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): Oct. 11, 1899.

8. AGE:

Years	Months	Days	If less than one day
47	7	14	..... hrs. ..... min.

9. Birthplace: Siloam Md.

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: George W. Washburn

13. Birthplace: Siloam Md.

MOTHER — 14. Maiden name: Georgana Mills

15. Birthplace: Near Siloam Md.

16. Informant: Mrs. Edna E. Washburn

Address: R.D. #1. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 28-47 (month) (day) (year)

Cemetery or crematory: Siloam Church Cem

Location: Siloam Md.

18. Funeral director: Hollowa & Walter R. Hollowa

Address: Salisbury Md.

19. 5/27/47 (Date rec'd by registrar) Carrie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1947, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1947 to May 25 1947 and that I last saw h[illegible] alive on 5/24/47 1947

Immediate cause of death: Cerebral Hemorrhage — DURATION

Due to:

Due to:

Other conditions: Chr. Nephritis

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. R. Gramm M.D. M. D. or other

Address: Salisbury, Md. Date signed: 5/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-C)

CERTIFICATE OF DEATH

14490

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Mardela
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Willey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widower

6.(b) Name of husband or wife: Sarah E. Willey

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept 3 - 1863

8. AGE: Years: 83 | Months: 8 | Days: 15 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Mardela Spgs. Md
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER
12. Name: Jabez Willey
13. Birthplace: Md

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Fanny E. Willey

Address: Mardela R.D. # Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-10-1947 (month) (day) (year)

Cemetery or crematory: Mardela

Location: Mardela Md

18. Funeral director: Graveson Bros

Address: Thurston, Md.

19. 6/10, 1947 (Date rec'd by registrar) Carrie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1947, at 7 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/28 1947, to 5/8 1947

and that I last saw him alive on 5/8 1947.

Immediate cause of death	DURATION
Hypostatic Pneumonia	hours
Due to	
Due to	
Other conditions Pneumonia Terminal	hours

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. 4/7/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: J. M. Hurst M. D. or other

Address ____ Date signed ____

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.